Reset

South Carolina Department of Social Services

MEDICAL STATEMENT FOR HOUSEHOLD MEMBERS

To be completed by a Licensed Medical Practitioner, for the purpose of evaluating the health of household members of a prospective foster/adoptive family.

Name of Household Member: _____

Relationship to Applicant: _____

I give permission for _____ to share information about me
Name of Licensed Medical Practitioner

with the Department of Social Services, for the purpose of completing a foster/adoptive home study.

_____ _____
Signature of Household Member/Parent Date

Does the household member have any contagious or communicable diseases? If so, please describe.

Does the household member have any health concerns that would affect or limit the family's ability to care for a child? If so, please describe.

Do you have any other concerns related to the placement of a child in the home? If so, please describe.

Completed by:

_____ _____
Licensed Medical Practitioner Date

Please print/type name and address of Licensed Medical Practitioner:

Please return form to: